



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING



ISMAEL AHMED
DIRECTOR

RE: CHILD CARE APPLICATION – FAMILY/GROUP HOME

Dear Applicant:

The following is information regarding application for a family child care home of 6 or less children or a group child care home of 7 – 12 children.

Instructions and additional materials are included which will assist you in completing the application.

Please complete and return all of the required application materials with a check or money order (which is non-refundable) payable to the "State of Michigan" in the amount of \$50.00 for a family child care home application or \$100.00 for a group child care home application to:

Michigan Department of Human Services
Cashier's Office
P.O. Box 30759
Lansing, MI 48909-8150

For additional information, please contact the Licensing Unit at (517) 241-2488 or toll free 866-685-0006 or Fax at (517) 241-1680.

Thank you.

Enclosures

FAMILY CHILD CARE HOME APPLICATION PROCESS 6 or less children

Return **ALL** of the items listed below as a **COMPLETE PACKET**. All items must be filled out and **returned together in the same envelope to:**

Michigan Department of Human Services
Cashier's Office
P.O. Box 30759
Lansing, MI 48909-8150

1. Child Care Application (BCAL-3970).
2. Supplemental Information Form (BCAL-3737).
3. A **\$50.00** check or money order, payable to the **State of Michigan**.
4. Proof of electronic fingerprint clearance for applicant only (see enclosure and utilize form BCAL-1326).
5. Licensing Record Clearance Forms (BCAL-1326) - It is necessary to complete one for **each non-applicant adult (18 or older) who resides in your home.**
6. A Licensing Medical Clearance Request (BCAL-3704) for you and each assistant caregiver. You must complete the Patient Information section before submitting the form to your physician for completion.
7. Documentation of TB test results for all persons in the home who are 14 years of age and older. Assistant caregivers must also have documentation of TB test results.
8. Documentation of valid infant/child/adult CPR and First Aid training from an approved trainer. (See [DHS CPR and First Aid Training](http://www.michigan.gov/dhs) website www.michigan.gov/dhs.)
9. Proof of inspection and approval of your heating system signed by a licensed heating contractor. This includes wood-burning stoves and any other permanently installed heating devices if used at any time in your home. Electric heat does not require an inspection.
10. Proof of recent inspection and approval of your fuel fired water heater by a licensing heating contractor or licensed plumbing contractor.
11. If you plan on using your basement to care for children, you must provide documentation that the level of radon gases does not exceed 4 picocuries per liter of air. If applicable, contact the Licensing Unit if you have questions.

REMINDER

Be sure to indicate on your application if you have a private well and/or septic system.

All the above items, must be returned to the Cashier's Office as **ONE PACKET**. **Incomplete application packets will be returned to you.**

Your application will be processed once the entire packet is received by the Licensing Unit is complete and an application fee receipt from the cashier's office has been received.

WHAT HAPPENS NEXT REGARDING

THE FAMILY CHILD CARE REGISTRATION PROCESS?

1. When you have returned the **required** application materials, they will be reviewed and evaluated. (An incomplete application packet will be returned to you.)
2. If the application indicates that your home has a **private well and/or septic system**, an inspection and approval of the system(s) are required. (Rule 400.1933(2)). This is done by your local health authority prior to registration, at no cost to you. **This inspection will be requested by the Licensing Unit.**
3. You will be scheduled for an orientation by your local licensing office.
 - This orientation lasts approximately 6 hours.
 - It will cover the licensing rules and the Child Care Organization Act.
 - Additional information will be provided which will help you to be successful in the business of caring for children.
 - Time will be provided for you to ask questions.
 - **Please do not bring your children.**
4. At the end of the orientation session, you will be given a Statement of Registration.
 - This is a legal document on which you certify that you are in compliance with the family child care home rules and the Child Care Organization Act [1973 PA 116](#).
 - You will be asked to take it with you to check your home before signing and returning it.
 - When you have determined that you are in compliance with the rules and the statute and you have returned the signed Statement of Registration, you will be issued a Certificate of Registration.
 - This registration is in effect for 3 years as long as you continue to meet the rules and reside at the same address.
5. Once you are registered, a licensing consultant will visit your home to assess how you are meeting the rules. REMINDER: IT IS YOUR RESPONSIBILITY TO BE IN COMPLIANCE WITH THE [RULE REQUIREMENTS](#) AT ALL TIMES.

Some items that must be available during the on-site inspection are:

 - At least 1 functioning multipurpose fire extinguisher, with a rating of not less than 2A-10BC, properly mounted on each floor that is used by children in care. [R400.1944(3)]
 - A smoke detector on each floor of your home. [R400.1944(1)]
 - A carbon monoxide detector on each floor that is used by children in care. [R400.1934(3)]
 - A posted evacuation and care plan for tornado, fire, and serious accident or injury. [R400.1945]
 - A written discipline policy. [R 400.1913(1)]
6. 10 clock hours of training must be completed each year by the applicant [R400.1905(1)] and 5 clock hours of training each year must be completed by each assistant caregiver [R400.1905(2)].

PLEASE NOTE: A certificate of registration is issued to a specific person at a specific address.

- **If you move, your certificate of registration is no longer valid.**
- If you plan to move, contact the BCAL Licensing Unit **prior** to the move so that you can apply for a registration at your new address.
- If you decide to no longer care for children, contact your local licensing office to request closure of your certificate of registration.

GROUP CHILD CARE HOME APPLICATION PROCESS 7 to 12 children

Return ALL of the items listed below as a COMPLETE PACKET. All items must be filled out and returned together in the same envelope to:

Michigan Department of Human Services
Cashier's Office
P.O. Box 30759
Lansing, MI 48909-8150

1. Child Care Application (BCAL-3970).
2. Supplemental Information Form (BCAL-3737).
3. Zoning Approvals for Child Care (BCAL-3748). Documentation of approval for a special use permit or other similar permit from your city or township, per the Michigan Zoning Enabling Act, 2006 PA 110. You must contact your local zoning authority to obtain this permit.
4. A **\$100.00** check or money order, payable to the **State of Michigan**.
5. Proof of electronic fingerprint clearance for applicant only (see enclosure and utilize form BCAL-1326).
6. Licensing Record Clearance Forms (BCAL-1326) – It is necessary to complete one for **each non-applicant adult (18 or older) who resides in your home**.
7. A Licensing Medical Clearance Request (BCAL-3704) for you and each assistant caregiver. You must complete the Patient Information section before submitting the form to your physician for completion.
8. Documentation of TB test results for all persons in the home who are 14 years of age and older. Assistant caregivers must also have documentation of TB test results.
9. Documentation of valid infant/child/adult CPR and First Aid training from an approved trainer. (See [DHS CPR and First Aid Training](http://www.michigan.gov/dhs) website www.michigan.gov/dhs.)
10. Proof of inspection and approval of your heating system signed by a licensed heating contractor. This includes wood-burning stoves and any other permanently installed heating devices if used at any time in your home. Electric heat does not require an inspection.
11. Proof of recent inspection and approval of your fuel fired water heater by a licensing heating contractor or licensed plumbing contractor.
12. If you plan on using your basement to care for children, you must provide documentation that the level of radon gases does not exceed 4 picocuries per liter of air. If applicable, contact the Licensing Unit if you have questions.

WHAT HAPPENS NEXT REGARDING THE GROUP CHILD CARE HOME APPLICATION PROCESS?

1. **Environmental Health Inspection** – If your application indicates that your home has a **private well and/or septic system**, an inspection and approval of the system(s) are required. This is done by your local health authority prior to licensure, at no cost to you. **This inspection will be requested by the Licensing Unit.**
2. You will be scheduled for an orientation by your local licensing office.
 - This orientation lasts approximately 6 hours.
 - It will cover the licensing rules and the Child Care Organization Act.
 - Additional information will be provided which will help you to be successful in the business of caring for children.
 - Time will be provided for you to ask questions.
 - **Please do not bring your children.**
3. **Licensing Inspection** – Once all required application materials have been submitted and are complete, a licensing consultant will inspect your home to assess compliance with the licensing rules. It is your responsibility to be in compliance with the rules and statute at the time of the inspection and at all times thereafter.

Items that must be available during the on-site inspection include:

- At least 1 functioning multipurpose fire extinguisher, with a rating of not less than 2A-10BC, properly mounted on each floor level that will be used by child in care [R400.1944(3)]
- A working smoke detector on each floor of your home [R400.1944(1)]
- A carbon monoxide detector on each floor that is used by children in care. [R400.1934(3)]
- A posted evacuation and care plan for tornado, fire, and serious accident or injury [R400.1945]
- A written discipline policy [R400.1913(1)]

IV. LICENSE ISSUANCE

As an applicant, you can expect the licensing process to take 3 to 6 months to complete **after** you submit a complete application packet. Individual circumstances may effect the actual time required to issue your license. Once it has been determined that you are in compliance with the [rules](#) and the [statute](#) you will be issued a 6 month provisional license.

1. Prior to the expiration of the 6 month provisional license you will receive a renewal application packet. After you submit a complete renewal application packet an on-site inspection will occur. If you continue to remain in compliance with the rules and the statute, you will then be issued a regular license that is valid for 2 years.
2. 10 clock hours of training must be completed each year by the applicant [R400.1905(a)] and 5 clock hours of training each year must be completed by each assistant caregiver. [R400.1905(2)]

PLEASE NOTE:

A license is issued to a specific person at a specific address.

- If you plan to move, contact the BCAL Licensing Unit **prior** to the move so that you can apply for a license at your new address.
- If you decide to no longer care for children, contact your local licensing office to request closure of your license.

IF YOU HAVE ANY QUESTIONS PLEASE CALL THE LICENSING UNIT AT **1-866-685-0006**, OR VISIT OUR [CHILD CARE](#) WEBSITE (www.michigan.gov/dhs).

<input type="checkbox"/> FAMILY – 6 or less GROUP – 7 to 12 <input type="checkbox"/> CENTER	CHILD CARE APPLICATION Bureau of Children and Adult Licensing Michigan Department of Human Services	FOR DHS USE ONLY: License Number:	
		Paid Amount: Cashier:	
<input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> RENEWAL <input type="checkbox"/> OTHER		OFFICE:	Consultant/Staff:

COMPLETE FOR CHILD CARE CENTER ONLY									
Facility Name				Corporate Name/Sponsoring Organization Name					
Address (Street Number and Name)				Address (Street Number and Name)					
City		State MI	Zip Code	City		State MI	Zip Code		
Telephone Number ()		County		Telephone Number ()		County			
Applicant's E-mail Address				Sponsoring Organization's E-mail Address					
Auspices Status (Check One) Governmental		<input type="checkbox"/> Local Government <input type="checkbox"/> County Government	<input type="checkbox"/> State Government <input type="checkbox"/> Community College	<input type="checkbox"/> State College/University <input type="checkbox"/> Public School	Send Mail To: <input type="checkbox"/> Center <input type="checkbox"/> Applicant		Corporate Status (Check One) <input type="checkbox"/> None <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit		
Non-Governmental (Check All That Apply)		<input type="checkbox"/> Church <input type="checkbox"/> Privately Owned	<input type="checkbox"/> Parent Cooperative <input type="checkbox"/> Employee Sponsors	<input type="checkbox"/> Private Funded Comm. Org. <input type="checkbox"/> Private School/College					

BCAL-3970 (Rev. 9-07) Previous edition 1-06 & 1-07 may be used. MS Word

☐ FAMILY – 6 or less

☐ GROUP – 7 to 12

SUPPLEMENTAL APPLICATION INFORMATION

Michigan Department of Human Services
Bureau of Children and Adult Licensing

LICENSE/APPROVAL/REGISTRATION
NUMBER FOR RENEWAL ONLY

☒ ORIGINAL

☐ RENEWAL

☐ OTHER

SECTION I APPLICANT AND FACILITY INFORMATION:

Applicant Name (Last, First, Middle)		Birthdate	Soc Sec or FED ID Number	Phone Number	
Co-applicant Name (If joint)		Birthdate	Soc Sec or FED ID Number	Phone Number	
Address (Street Number & Name)		City		State MI	Zip Code
Name of Adult Who Will Assist in an Emergency		Telephone ()		Age	
Address (Street Number & Name)		City		State MI	Zip Code
Assistant Caregiver, If Any	Age	Assistant Caregiver, If Any		Age	

LIST ALL PERSON(S) LIVING IN YOUR HOME AND RELATIONSHIP

Name	Birthdate	Relationship	Name	Birthdate	Relationship
Name	Birthdate	Relationship	Name	Birthdate	Relationship
Name	Birthdate	Relationship	Name	Birthdate	Relationship

Name(s)/date(s) for TB test for all persons in home 14 years of age or older:

Water Type: (check one) <input type="checkbox"/> Well <input type="checkbox"/> Public	Sewer Type: (check one) <input type="checkbox"/> Septic <input type="checkbox"/> Public	Water Heater (check one) <input type="checkbox"/> Gas <input type="checkbox"/> Electric	Year Home was Built:		
Heat Type: (check all that apply) <input type="checkbox"/> Gas <input type="checkbox"/> Electric <input type="checkbox"/> Propane <input type="checkbox"/> Wood <input type="checkbox"/> Forced Air <input type="checkbox"/> Boiler			Date of Furnace Inspection		
Have you been previously or presently registered/licensed for children or adults? <input type="checkbox"/> No <input type="checkbox"/> Yes (License No.) ▶		Have you applied for any other registration/license to care for children or adults? <input type="checkbox"/> No <input type="checkbox"/> Yes (License No.) ▶			
Number of Children for whom you wish to be licensed.		Who will provide food?		Length of time in present home.	
List room names and sizes for children's use.		Days and Time of Operation (indicate a.m./p.m.):			
		Sunday	From:	To:	
Where will children sleep/nap? Describe sleeping arrangements.		Monday	From:	To:	
		Tuesday	From:	To:	
Directions to Home (Indicate Nearest Intersection).		Wednesday	From:	To:	
		Thursday	From:	To:	
		Friday	From:	To:	
		Saturday	From:	To:	

SECTION II – PROGRAM AND TRAINING INFORMATION

What will the children do during the day? Describe planned daily activities including provisions for outdoor play. List toys/materials – attach a separate sheet, if necessary. 							
How do you plan to supervise children at all times (in your home, outdoors, on field trips, etc.) – attach a separate sheet, if necessary. 							
Training (Check all that apply) <input type="checkbox"/> Have Completed: <input type="checkbox"/> Infant & Child CPR <input type="checkbox"/> Adult CPR <input type="checkbox"/> First Aid Training <input type="checkbox"/> Have Not Completed: <input type="checkbox"/> Infant & Child CPR <input type="checkbox"/> Adult CPR <input type="checkbox"/> First Aid Training		Name of Training Agency Name of Training Agency		Date Card Received Date Card Received			
I have <input type="checkbox"/> /have not <input type="checkbox"/> completed 10 hours of training annually.		All assistant caregivers have <input type="checkbox"/> /have not <input type="checkbox"/> completed 5 hours of training annually.					
Applicant/Licensee Signature		Date		Co-Applicant/Licensee Signature		Date	

Authority: 1973 PA 116

Completion: Required

Penalty: Applicant cannot be licensed/registered

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.



Identix Identification Services has recently been merged with Integrated Biometric Technology, an L-1 Identity Solutions Company.

Schedule a Fingerprinting Appointment - Michigan

Welcome to L-1 Identity Solutions

Our goal is to provide the applicant a fast, simple, convenient, and professional fingerprinting experience. We understand that the sooner the background check process is completed, the sooner you can become licensed or employed. Here's how to get started:

1. Review the **list of locations for a facility near you**.
2. Have information with you, such as your agency's identification number and the reason you're being fingerprinted.
3. Click on the "**Schedule a Fingerprinting Appointment On-line**" link on the left or call us toll-free at 1-866-226-2952 (8am-5pm EST) to schedule an appointment.
4. Arrive at the facility at your appointed time.
5. Bring the following with you to your fingerprinting appointment: driver's license or other valid form of identification, your Michigan Livescan Fingerprint Request Form (from your employer/licensing agency), and the form of payment you selected when you made your appointment.
6. The technician will scan your fingerprints and submit your data. This normally takes less than five minutes.
7. You will receive a signed receipt at the end of your fingerprinting session which can be submitted to your agency for proof of fingerprinting, if needed.
8. The results will be sent directly to the agency responsible for employment or licensing from the Michigan State Police.

For more information or to schedule an appointment at a convenient location near you, please contact:

Integrated Biometric Technology

Phone: 1-(866) 226-2952

Web: **www.l1id.com**

Pay by credit card over the phone. Check or Money Order at time of appointment. No cash accepted.

Agency ID: 10971L

LICENSING RECORD CLEARANCE REQUEST INSTRUCTIONS

There are four purposes to this form:

1. Produce a Department of State Police check regarding the possible existence of a conviction record.
2. Produce a Department of Human Services Central Registry File check regarding the possible existence of a substantiated child abuse or neglect record.
3. Produce a BCAL Files check against current or previous licensee status of the applicant in any county of the state.
4. **Day Care Applicants Only:** Live Scan Fingerprint Request is required for applicant, licensee, and/or program director. Refer to enclosed information regarding locations to conduct fingerprinting. The Licensing Record Clearance (BCAL-1326) must be taken with you at the time the FBI fingerprint is conducted. **Note: The TCN# will be filled in by the Fingerprint Specialist and must be inserted prior to submitting application to BCAL.**

The existence of a conviction record or a substantiated child abuse or neglect record does not necessarily disqualify an applicant for licensure. However, it does provide the Agency with information, which will be carefully evaluated by licensing staff.

A failure on the part of an applicant to provide BCAL with the information and authorization requested on this form may be sufficient cause to deny issuance of a license.

AUTHORITY:	1973 PA 116 1979 PA 218	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
COMPLETION:	Required	
CONSEQUENCE:	Licensure may be denied.	

LICENSING RECORD CLEARANCE REQUEST STATE OF MICHIGAN

Department of Human Services
Bureau of Children and Adult Licensing

DIRECTIONS FOR COMPLETING FORM: <ul style="list-style-type: none"> Please read the accompanying instructions before completing this form. Please type or print CLEARLY so that the information completed can be read. Mail completed form to BCAL Central office. 				LIVESCAN FINGERPRINT REQUEST <i>This section for day care only.</i>				
SECTION I: REQUESTOR INFORMATION (Must be completed by licensing consultant/worker)				Agency ID: 10971L TCN# _____ (MUST BE FILLED IN PRIOR TO RETURNING)				
Licensing Consultant/Worker Name, Address and Phone Number <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> Department of Human Services Bureau of Children and Adult Licensing 7109 W. Saginaw, 2nd Floor P. O. Box 30650 Lansing, MI 48909-8150 </div>				Date Fingerprinted: _____ Type of Picture I.D. presented: _____ DCL(Day Care License)				
LICENSEE/APPLICANT NAME			County		LICENSE NUMBER (If assigned)			
LICENSE/APPLICATION TYPE <input checked="" type="checkbox"/> Family/Group Child Care Home <input type="checkbox"/> Child Care Center <input type="checkbox"/> Institution/Agency <input type="checkbox"/> Camp								
THE PERSON BEING CLEARED IS: <input type="checkbox"/> Adult Member of Household (specify relationship to licensee): <input type="checkbox"/> Applicant <input type="checkbox"/> Licensee/Licensee Designee <input type="checkbox"/> Administrator <input type="checkbox"/> Responsible Person (In charge of daily operations) <input type="checkbox"/> Director/Program Director								
SECTION II: CLEARANCE INFORMATION (To be completed by applicant or other person to be cleared – If more than one person is named on the application, each is to complete a BCAL-1326)								
NAME (Last, First, Middle Jr., II, etc.)			SEX	BIRTH DATE		SOCIAL SECURITY NUMBER		
MARITAL STATUS <input type="checkbox"/> SGL <input type="checkbox"/> MAR <input type="checkbox"/> DIV		ALSO KNOWN AS (Aliases, Maiden Name, Previous Married Name(s))			MICHIGAN DRIVERS LICENSE NUMBER			
ADDRESS (Street Number and Name)				HOW LONG HAVE YOU LIVED IN THIS STATE? _____		RACE _____		
CITY		COUNTY	STATE	ZIP CODE	PHONE NUMBER		HEIGHT _____	
						WEIGHT _____		
<ul style="list-style-type: none"> I am aware that Michigan Department of State Police records will be checked for information regarding criminal convictions under authority of the Good Moral Character Statute. I am aware that the Department of Human Services Central Registry will be checked for information concerning substantiated child abuse and neglect. I certify that the information I have given on the form is, to the best of my ability, true and correct. The Department may perform this check at any time while I am licensed. 								
HAVE YOU EVER BEEN CONVICTED OF A CRIME, FELONY OR MISDEMEANOR? <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, explain) Type, Location, and Date of Conviction(s)								
SIGNATURE OF PERSON TO BE CLEARED						DATE		

SECTION III: CENTRAL RECORDS CLEARANCE (BCAL Use Only)			SECTION IV: CONVICTION CLEARANCE		
PREVIOUS LICENSE? <input type="checkbox"/> NO <input type="checkbox"/> YES		LICENSE NUMBER	INITIALS/CLEARANCE DATE		
IS PROTECTIVE SERVICES INFORMATION ON FILE? <input type="checkbox"/> NO <input type="checkbox"/> YES			INITIALS/CLEARANCE DATE		
IS MICHIGAN PUBLIC SEX OFFENDER REGISTRY (PSOR) INFORMATION ON FILE? <input type="checkbox"/> NO <input type="checkbox"/> YES			INITIALS/CLEARANCE DATE		
Disclaimer: Any and all fingerprints processed with incorrect fingerprint codes/reasons, etc. are the responsibility of the REQUESTING AGENCY. MSP will charge for second requests due to incorrect fingerprint reason.					

If you have multiple individuals in the home that will require additional forms, please print additional copies of this form before filling it out.

MEDICAL CLEARANCE REQUEST
Michigan Department of Human Services
Bureau of Children and Adult Licensing

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE
MAIL TO
➔

Licensing Consultant (Name, Address, Phone)

Department of Human Services
Bureau of Children and Adult Licensing
7109 W. Saginaw, 2nd Floor
P.O. Box 30650
Lansing, MI 48909-8150

License Application Type

- ☐ Adult Foster Care (24-Hour Care)
☐ Child Foster Care (24-Hour Care)
☒ Child Care (Less Than 24-Hour Care)
☐ Capacity _____

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the care facility listed above and to the Michigan Department of Human Services, Bureau of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of children/dependent adults.	Date
	Patient's Signature
	Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- This individual is, or will be, employed in a child/dependent adult care setting.
- It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child/dependent adult and the quality and manner of his/her care.
- To assist us in this determination, you are being asked to answer the following.

Has this Person Been Tested for T.B.? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes ➔	Date Tested	Test Type <input type="checkbox"/> Skin Test <input type="checkbox"/> X-Ray	Results <input type="checkbox"/> Positive (Explain in Comments) <input type="checkbox"/> Negative
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How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults.
- ☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around children/dependent adults. Explain in Comments if reasonable accommodation may be needed.
- ☐ Physical/mental condition or health problem exists which would affect the ability to work with or around children/dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: 1973 PA 116
1979 PA 218
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.